FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036012

Facility Name: Breese Nursing Home

Address: 1155 North First Street (Number) Breese (City) 62230 (Zip Code)

County: Clinton

Telephone Number: (618) 526-4521 **Fax #** (618) 526-2833

IDPA ID Number: 37-1259462001

Date of Initial License for Current Owners: 03/09/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,402	6,895	2,937	18,234	8
9	SNF/PED					9
10	ICF	6,765	4,105		10,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,167	11,000	2,937	29,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.19%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 2,937

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,013	3,220	6,576	185,809		185,809		185,809			1
2	Food Purchase		136,260		136,260		136,260	(2,232)	134,028			2
3	Housekeeping	58,712	12,616		71,328		71,328		71,328			3
4	Laundry	43,553	18,584	1,938	64,075		64,075		64,075			4
5	Heat and Other Utilities			98,282	98,282		98,282	(30)	98,252			5
6	Maintenance	67,403	11,260	24,147	102,810		102,810		102,810			6
7	Other (specify):* Sanitation			9,170	9,170		9,170		9,170			7
8	**TOTAL General Services**	345,681	181,940	140,113	667,734		667,734	(2,262)	665,472			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,326,186	65,316	1,802	1,393,304		1,393,304	(11)	1,393,293			10
10a	Therapy		446	362,055	362,501		362,501		362,501			10a
11	Activities	36,709	1,586	1,450	39,745		39,745		39,745			11
12	Social Services	47,834		1,229	49,063		49,063		49,063			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,410,729	67,348	374,936	1,853,013		1,853,013	(11)	1,853,002			16
	C. General Administration											
17	Administrative	87,522			87,522		87,522		87,522			17
18	Directors Fees											18
19	Professional Services			25,604	25,604		25,604	(826)	24,778			19
20	Dues, Fees, Subscriptions & Promotions			13,808	13,808	783	14,591	(3,097)	11,494			20
21	Clerical & General Office Expenses	105,128	19,275	42,376	166,779		166,779	(1,820)	164,959			21
22	Employee Benefits & Payroll Taxes			234,897	234,897		234,897	(11,908)	222,989			22
23	Inservice Training & Education			209	209	67	276		276			23
24	Travel and Seminar			4,626	4,626	(850)	3,776		3,776			24
25	Other Admin. Staff Transportation		7,319		7,319		7,319		7,319			25
26	Insurance-Prop.Liab.Malpractice			64,134	64,134		64,134		64,134			26
27	Other (specify):*											27
28	**TOTAL General Administration**	192,650	26,594	385,654	604,898		604,898	(17,651)	587,247			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,949,060	275,882	900,703	3,125,645		3,125,645	(19,924)	3,105,721			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Breese Nursing Home #0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			94,431	94,431		94,431	20,886	115,317			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			210,929	210,929		210,929	(9,054)	201,875			32
33	Real Estate Taxes			23,490	23,490		23,490		23,490			33
34	Rent-Facility & Grounds			14,225	14,225		14,225		14,225			34
35	Rent-Equipment & Vehicles			2,258	2,258		2,258		2,258			35
36	Other (specify):* Mort. Ins. Prem.			11,956	11,956		11,956		11,956			36
37	TOTAL Ownership			357,289	357,289		357,289	11,832	369,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,617	26,086	96,703		96,703		96,703			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		70,617	87,406	158,023		158,023		158,023			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,949,060	346,499	1,345,398	3,640,957		3,640,957	(8,092)	3,632,865			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,160)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,886	30		9
10	Interest and Other Investment Income	(9,054)	32		10
11	Discounts, Allowances, Rebates & Refunds	(72)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,770)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,424)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance	(4,438)	22		21
22	Special Legal Fees & Legal Retainers	(826)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,653)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,581)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,092)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,092)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Maintenance Refund	$ (30)	5	1
2	Offset Medical Supplies Reimbursement	(11)	10	2
3	Offset Clerical Refund	(50)	21	3
4	Eliminate 2006 & 2007 IDPH license pd in 2005	(1,990)	20	4
5	Eliminate Owners' Health Insurance	(7,470)	22	5
6	Eliminate Civic Dues	(150)	20	6
7	Record 2005 IDPH License paid for in 2004	2,120	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,581)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,232)	0	0	0	0	0	0	0	0	0	0	(2,232)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(30)	0	0	0	0	0	0	0	0	0	0	(30)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,262)	0	0	0	0	0	0	0	0	0	0	(2,262)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11)	0	0	0	0	0	0	0	0	0	0	(11)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(11)	0	0	0	0	0	0	0	0	0	0	(11)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(826)	0	0	0	0	0	0	0	0	0	0	(826)	19
20	Fees, Subscriptions & Promotions	(3,097)	0	0	0	0	0	0	0	0	0	0	(3,097)	20
21	Clerical & General Office Expenses	(1,820)	0	0	0	0	0	0	0	0	0	0	(1,820)	21
22	Employee Benefits & Payroll Taxes	(11,908)	0	0	0	0	0	0	0	0	0	0	(11,908)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,651)	0	0	0	0	0	0	0	0	0	0	(17,651)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,924)	0	0	0	0	0	0	0	0	0	0	(19,924)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Breese Nursing Home** **#** **0036012** **Report Period Beginning:** **01/01/2005** **Ending:** **12/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	20,886	0	0	0	0	0	0	0	0	0	0	20,886	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,054)	0	0	0	0	0	0	0	0	0	0	(9,054)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	11,832	0	0	0	0	0	0	0	0	0	0	11,832	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,092)	0	0	0	0	0	0	0	0	0	0	(8,092)	45

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark E. Halloran	50.00%					
Garrett C. Reuter	50.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark E. Halloran	President		50.00%	0	12	30.00%	Salary	$ 12,033	17,1	1
2	Garrett C. Reuter		Counsel	50.00%	0	12	30.00%	Salary	12,033	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 24,066		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Gershman Investment Group		X	Refinance Mortgage	$17,832.17	3/16/2000	$ 2,478,900	$ 2,387,120	3/16/2035	8.1250	$ 194,678	1
2												2
3								Amortization of Loan Costs			3,257	3
4												4
5												5
	Working Capital											
6	Mark Halloran & Garrett											6
7	Reuter	X		Working Capital		12/31/02	137,531	167,767		7.0000	12,994	7
8												8
9	TOTAL Facility Related				$17,832.17		$ 2,616,431	$ 2,554,887			$ 210,929	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(9,054)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,054)	14
15	TOTALS (line 9+line14)						$ 2,616,431	$ 2,554,887			$ 201,875	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,956 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Breese Nursing Home **#** 0036012 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 23,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 23,190	2
3. Under or (over) accrual (line 2 minus line 1).	$ (610)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 24,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 23,490	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	24,640	8
2001	24,416	9
2002	24,198	10
2003	22,904	11
2004	23,190	12

The payment on line 2 was for the 2004 tax year.

The accrual used on line 4 was based on the 2004 tax paid.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Breese Nursing Home COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036012

CONTACT PERSON REGARDING THIS REPORT Mark Halloran, President

TELEPHONE (618) 632-2500 FAX #: (618) 622-0800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-22-252-008	Sec 22 Twp 2 Rng 4 Pt W 1/2 NE	$ 23,190.10	$ 23,190.10
2.		NE 4A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,190.10	$ 23,190.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,286 B. General Construction Type: Exterior Masonry Frame Reinforced Concrete Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	174,242	1990	$ 15,400	1
2					2
3	TOTALS	174,242		$ 15,400	3

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1990	1975	$ 1,750,695	$ 55,578	31.5	$ 55,578	$	$ 877,661	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg Balance			1975	10,000	317	31.5	317		5,013	9
10	Roof			1990	101,563	3,224	31.5	3,224		49,600	10
11	Air conditioner			1990	2,828	90	31.5	90		1,397	11
12	Interior Renovation			1990	1,292	41	31.5	41		617	12
13	Air conditioner Pad			1990	2,645	78	15	44	(34)	2,645	13
14	Roof			1991	48,265	1,532	31.5	1,532		22,535	14
15	Handrails			1991	4,884	155	31.5	155		2,254	15
16	Soffits & Siding			1991	11,204	356	31.5	356		5,227	16
17	Carpet			1991	1,987		7			1,987	17
18	Air Conditioner			1991	4,755	151	31.5	151		2,182	18
19	HVAC - Dining Room			1991	5,510	175	31.5	175		2,318	19
20	Cubicle Tracking			1992	1,815		7			1,815	20
21	Plastering			1992	1,952	62	31.5	62		790	21
22	Cubicle Tracking			1993	657		20	33	33	418	22
23	Carpet & Tile			1993	1,481		5			1,481	23
24	Air Conditioning			1993	5,877	151	10		(151)	5,877	24
25	Fire Alarm			1993	10,700	274	15	713	439	8,737	25
26	Front Door			1994	1,368	35	10		(35)	1,368	26
27	Electrical Wiring			1994	9,131	234	20	457	223	5,251	27
28	Back Patio			1994	5,137	303	10		(303)	5,137	28
29	Landscaping			1994	1,221	72	10		(72)	1,221	29
30	Front Parking Lot			1994	80,603	4,760	10		(4,760)	80,603	30
31	Lighting & Ceiling			1994	2,110		10			2,110	31
32	Gutters & Shutters			1994	2,111	54	27	78	24	879	32
33	Dining Room Improvements			1994	2,558	66	27	95	29	1,051	33
34	Plumbing			1994	4,528	116	20	227	111	2,679	34
35	Ceiling Tile			1994	614	16	12	51	35	579	35
36	Laundry Improvements			1994	1,162	30	27	43	13	509	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Administrative Office Improvements	1994	$ 1,048	$ 27	15	$ 70	$ 43	$ 821	37
38	Water Softener	1994	3,661	94	12	305	211	3,610	38
39	Air Conditioners	1994	31,460	807	10		(807)	31,460	39
40	Window Blinds	1995	6,010		20	300	300	3,030	40
41	Land Improvements	1995	1,224	72	10	102	30	1,224	41
42	Sign	1995	2,455		12	205	205	2,201	42
43	Parking Lot Lighting	1995	7,456		15	497	497	5,343	43
44	Flag Pole	1995	1,511	89	20	76	(13)	806	44
45	Landscaping	1995	2,206	130	10	110	(20)	2,206	45
46	Landscaping	1996	2,927		10	293	293	2,782	46
47	Kitchen Renovations	1996	13,339		25	534	534	5,071	47
48	Window Screens	1996	914		5			914	48
49	Remodel Nurse Station	1996	1,077		25	43	43	409	49
50	Reception Room Addition	1996	3,721		25	149	149	1,414	50
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	391	51
52	Shrubs	1997	1,001	59	15	67	8	568	52
53	Fence	1997	1,141	67	15	76	9	672	53
54	Fixtures	1997	2,835		10	283	283	2,433	54
55	Windows	2000	35,000	897	10	3,500	2,603	21,000	55
56	Light Fixtures	2000	1,500	38	10	150	112	900	56
57	Sink Fixtures	2000	7,350	188	20	367	179	2,205	57
58	10 Ton HVAC	2000	10,000	256	17	588	332	3,528	58
59	Water Softener	2000	40,000	1,026	12	3,333	2,307	19,999	59
60	Water Heater	2000	1,500	38	15	100	62	600	60
61	Air Handling Unit	2000	3,000	77	15	200	123	1,200	61
62	Rear Parking Lot	2000	44,000	2,743	15	2,933	190	17,599	62
63	Dumpster Pad	2000	900	56	15	60	4	360	63
64	Shower Room Remodel	2001	15,000	385	15	1,000	615	5,000	64
65	Grab Bars	2002	4,800	123	15	320	197	1,280	65
66	Tuck Point	2002	1,000	26	15	67	41	268	66
67	Regrout	2002	1,500	39	15	100	61	400	67
68	Air Handler	2002	3,000	77	15	200	123	800	68
69	Remodel Sprayout Room	2002	2,481	64	15	165	101	778	69
70	TOTAL (lines 4 thru 69)		$ 2,334,700	$ 75,248		$ 79,656	$ 4,408	$ 1,235,213	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,334,700	$ 75,248		$ 79,656	$ 4,408	$ 1,235,213	1
2	Drainage	2002	1,500	81	15	100	19	400	2
3	Roof	2003	3,697	117	10	370	253	863	3
4	Floor Tile	2004	47,390	1,215	10	4,739	3,524	4,739	4
5	Door Alarm	2004	6,074	156	10	607	451	1,113	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,393,361	$ 76,817		$ 85,472	$ 8,655	$ 1,242,328	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 227,089	$ 14,932	$ 26,326	$ 11,394	5-20 Yrs	$ 136,778	71
72	Current Year Purchases	28,571	782	782		5-10 Yrs	782	72
73	Fully Depreciated Assets	349,519					349,519	73
74								74
75	TOTALS	$ 605,179	$ 15,714	$ 27,108	$ 11,394		$ 487,079	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1991 Van	1991	$ 21,781	$	$	$	5	$ 21,781	76
77	Facility Business	Wheelchair Lift	1996	4,345		362	362	12	3,621	77
78	Facility Business	1993 Ford E150	2003	9,500	1,900	2,375	475	4	5,740	78
79										79
80	TOTALS			$ 35,626	$ 1,900	$ 2,737	$ 837		$ 31,142	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,049,566	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 94,431	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,317	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,886	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,760,549	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO
16. Rental Amount for movable equipment: $ 2,258 Description: Dishwasher
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[ ]
HOURS PER CNA	____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
HOURS PER CNA	____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	4,580	$ 152,256	$ 225	4,580	$ 152,481	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,275	64,224	28	1,275	64,252	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2 & 3	hrs		4,050	145,575	193	4,050	145,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				70,617		70,617	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Amb., X-Ray & Lab	39,3				26,086			26,086	13
14	TOTAL			$	9,905	$ 388,141	$ 71,063	9,905	$ 459,204	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 669,548	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	502,972		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,985		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,220,005	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,378,917		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	638,383		16
17	Accumulated Depreciation (book methods)	(1,715,830)		17
18	Deferred Charges	95,007		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,411,877	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,631,882	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 148,762	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,430		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,936		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,100		32
33	Accrued Interest Payable	16,162		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Shareholders	167,767		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 445,157	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,387,120		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,387,120	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,832,277	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (200,395)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,631,882	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (434,961)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (434,961)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	309,566	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(75,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 234,566	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (200,395)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,818,728	1
2	Discounts and Allowances for all Levels	(699,932)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,118,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	750,185	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 750,185	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,160	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,632	19
20	Radiology and X-Ray	13,901	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 66,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,054	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,054	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,024	28
28a	Gain or Loss on Disposal of Fixed Assets	(229)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,795	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,950,523	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	667,734	31
32	Health Care	1,853,013	32
33	General Administration	604,898	33
	B. Capital Expense		
34	Ownership	357,289	34
	C. Ancillary Expense		
35	Special Cost Centers	96,703	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,640,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	309,566	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 309,566	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,883	2,039	$ 52,751	$ 25.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,649	12,410	251,456	20.26	3
4	Licensed Practical Nurses	18,780	20,150	350,098	17.37	4
5	CNAs & Orderlies	57,456	61,654	648,515	10.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,892	4,145	36,709	8.86	10
11	Social Service Workers	3,451	3,835	47,834	12.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,324	18,536	176,013	9.50	15
16	Dishwashers					16
17	Maintenance Workers	4,468	4,803	67,403	14.03	17
18	Housekeepers	6,882	7,203	58,712	8.15	18
19	Laundry	5,707	5,893	43,553	7.39	19
20	Administrator	2,077	2,250	63,456	28.20	20
21	Assistant Administrator					21
22	Other Administrative	1,203	1,203	24,066	20.00	22
23	Office Manager					23
24	Clerical	8,087	8,718	105,128	12.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,020	2,074	23,366	11.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,879	154,913	$ 1,949,060 *	$ 12.58	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	136	$ 6,576	1,3	35
36	Medical Director	Contract	8,400	10,3	36
37	Medical Records Consultant	13	483	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,320	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,229	11,3	44
45	Social Service Consultant	Contract	1,229	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	149	$ 19,237		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Halloran	Owner	50.00	$ 12,033
Garrett Reuter	Owner	50.00	12,033
Joseph Hussman	Administrator	0.00	63,456
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,522

B. Administrative - Other

Description	Amount
Section Not Applicable	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co.	Accounting	$ 11,900
Wenzel & Associates	Accounting	3,960
Greensfelder, Hemker, & Gale	Legal	405
Griffin, Winning, Cohen, & Bodewes	Legal	1,176
Paychex, Inc.	Accounting	8,163
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,604

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,582
Unemployment Compensation Insurance	19,745
FICA Taxes	149,092
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	2,100
Employee Exams	1,005
401(k) Fees	3,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,989

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,120
Advertising: Employee Recruitment	2,490
Health Care Worker Background Check	
(Indicate # of checks performed 36)	650
Promotional Advertising	1,653
Dues, Subscriptions & Licenses	5,294
Miscellaneous Expenses	940
Less: Public Relations Expense	( )
Non-allowable advertising	(1,653)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,494

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,328
Seminar Expense	2,448
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,776

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,160**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **C.J. Schlosser & Company, L.L.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

CARING FIRST, INC. D/B/A BREESE NURSING HOME
RECLASSIFICATIONS
MEDICAID COST REPORT
12/31/2005

	AMOUNT	LN #
A		
DUES, FEES, SUBSCRIPTIONS & PROMOTIONS	783	20
INSERVICE TRAINING & EDUCATION	67	23
SEMINARS & TRAVEL	(850)	24
TO RECLASSIFY EXPENSE MISPOSTINGS		

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE V, LINE 25
12/31/2005

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT	$ 7,319
	$ 7,319

** ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTTED WHICH WERE LESS THAN $250.00 EACH.

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE XVII
12/31/2005

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	$ 309,566
DEPRECIATION ADJUSTMENT	(27,792)
LIFE INSURANCE & ACCRUED VACATION ADJUSTMENT	5,910
DISALLOWED ENTERTAINMENT	322
TAX NET INCOME	$ 288,006

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2005

Pass Through Payments for Social Services	$ 2,453
Flu Vaccines	1,578
Medical Records Copies	34
SBC Rebate	50
Maintenance Reimbursements	30
Food Rebates	72
Nursing Supplies Reimbursements	11
Donations	240
Forfeited Flexible Spending A/C Money from 2004	187
Write off prior year's outstanding checks	1,359
Miscellaneous	10
	$ 6,024

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2005

NAME OF PERSONS ATTENDING	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST
Tara Hamilton	DON	6/1/2005	Springfield	MDS, QI, RAPS Seminar	IHCA	$ 190
Mary Perez	Restorative RN					
Marcia Rakers	MDS	6/2/2005	Mt. Vernon	MDS, QI, RAPS Seminar	IHCA	190
Diane Huelskamp	MDS					
Joe Husmann	Administrator	6/15/2005	Mt. Vernon	New Medicare Prescription Drug Program	IHCA	635
Tara Hamilton	DON					
Lou Heiman	Social Services					
Mary Perez	Restorative RN					
Donna Hustedde	Accounts Receivable					
Joe Husmann	Administrator	9/12/2005	Peoria	IHCA Convention	IHCA	1,195
Marcia Rakers	MDS	9/14/2005				
Diane Huelskamp	MDS					
Mary Perez	Restorative RN					
Carolyn Gebke	Dietary Director					
Connie Furman	Activity Director					
Donna Hustedde	Accounts Receivable					
					Audio tape of IHCA Convention Seminar	238
						2,448
					Travel cost for convention	1,328
						$ 3,776